PRECIOUS PEARLS HOME HEALTH CARE SERVICES, INC.

EMPLOYEE HEALTH ASSESSMENT

O Pre-employment O Annual Assessment O Other:_____

Name:	Marital Status: O M O S O W	Sex: O M O F
Address:	DOB:	Title:
Emergency Contact:		Relationship:
Emergency Address:		Telephone#:

INDICATE ILLNESS EXPERIENCED BY YOU OR FAMILY HISTORY			HAVE YOU HAD ANY ILLNESS BELOW SINCE LAST ASSESSMENT		
CONDITION	YES	NO	CONDITION	YES	NO
DIABETES			MIGRAINE HEADACHES		
KIDNEY DISEASE			FAINTING OR DIZZINESS		
HEART DISEASE			WEIGHT GAIN/LOSS		
HIGH BLOOD PRESSURE			CHANGE IN ENERGY LEVEL		
ARTHRITIS			FREQUENT COUGH		
TUBERCULOSIS			BLOOD IN SPUTUM		
MENTAL ILLNESS			SHORTNESS OF BREATH		
EPILEPSY /CONVULSIONS			CHEST PAIN/PRESSURE IN CHEST		
CANCER			SWELLING IN LEGS/FEET		
LATEX ALLERGY			PAIN IN CALF WHEN WALKING		
TB SCREEN (HISTORY+ PPD)			CHANGE IN BOWEL HABITS		
CHEST PAIN			BACK PAIN		
LINGERING COUGH			PAIN WHEN URINATING OR BLOOD IN URINE		
LOSS OF ENERGY			HIGH BLOOD PRESSURE		
UNEXPLAINED WEIGHT LOSS IN PAST YEAR			INFECTIOUS DISEASE		
INCREASED SWEATING AT NIGHT			INCREASED THIRST		
			PERSISTANT SORES OR LUMPS		

Do you smoke? O Yes O No If yes, how many packs a day?

Do you drink alcoholic beverages? O Yes O No If yes, how much?

Do you take depressant, stimulant, narcotic drugs that alter your behavior? O Yes O No If yes, specify:

Do you take prescription medications? O Yes O No If yes, list below:

Name of your physician?

Address: Telephone #:

I have read the above and declare that I have no injury, illness or ailment other than as specifically identified that may interfere with the performance of my job responsibilities. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

Signature: Date:

PRECIOUS PEARLS HOME HEALTH CARE SERVICES, INC.

EMPLOYEE PHYSICAL EXAMINATION REPORT

O Pre-Employment Physical Assessment O Annual Assessment O Return to work/LOA O other:

Name:	Marital Status: O M O s O w	Sex: O M O F
Address	SS #:	Title:

PHYSICAL EXAMINATION					
HEAD/ENT:					
EYES:					
NECK:					
BREASTS:					
LUNGS:					
CARDIOVASCULAR:					
MUSCULOSKELETAL:					
ABDOMEN:					
GENITOURINARY:					
CENTRAL NERVOUS SYSTEM:					
COM M ENTS:					
HT:		B/P:	PULSE:	RESP:	TEM P:

LABORATORY TEST RESULTS

TEST	DATE PERFORMED	RESULTS PROVIDE LAB VALUES AND INTERPRETATION	
RUBELLA TITER		NON-IMMUN E IMMUNE **LAB VALUE:**	
MEASLES TITER		NON-IMMUNE IMMUNE LAB VALUE:	
PPD (ANNUALLY)	1. DATE IMPLANTED	1. DATE READ:	RESULTS (mmxmm):
	2. DATE IMPLANTED	2. DATE READ:	RESULTS (mmxmm):
CHEST X-RAY (+PPD)	Date:	Results:	

IMMUNIZATIONS:	DATE	**DATE**	DATE
RUBELLA	1.		
RUBEOLA/MEASLES	1.	2.	
HEPATITIS B VACCINE	1.	2.	3.
OTHER:			

This individual is free from any health impairment that is a potential risk to the patient or other employee or which may interfere with the performance of his/her duties including habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter behavior.

O This individual is able to work with the following limitations:

O This individual is not physically/mentally able to work. *(specify reason):*

Physician Signature:_____License. **No.**_____Date:_____